Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

TO: **(1)**_____ County Office
Department for Community Based Services

TO: **(2)**_____
Department for Mental Health/Mental Retardation

FROM: **(3)**_____
Case Management Agency

DATE: **(4)**_____

SUPPORTS FOR COMMUNITY LIVING WAIVER PROGRAM ADMISSION

(1)_____
(Last Name) (First Name) (MI) (Social Security Number)

_____KY_____
(Address) (City) (Zip) (Phone number)

(2) Was admitted to the Support for Community Living Program on _____
(Date)

(3) Case Management Agency_____

_____
(Phone Number) (Provider #)

_____KY _____
(Address) (City) (Zip Code)

(4) Primary Provider_____

_____
(Phone) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)

SUPPORTS FOR COMMUNITY LIVING WAIVER PROGRAM DISCHARGE

(1)_____
(Last Name) (First Name) (MI) (Social Security Number)

_____KY_____
(Address) (City) (Zip) (Phone number)

(2) Discharged from the Supports for Community Living Program on _____
(Date)

(3) Case Management Agency_____

_____
(Phone Number) (Provider #)

_____KY _____
(Address) (City) (Zip Code)

(4) Primary Provider_____

_____
(Phone) (Provider #)

_____ KY _____
(Address) (City) (Zip Code)

SUPPORTS FOR COMMUNITY LIVING PROGRAM TRANSFER

(1)_____
(Last Name) (First Name) (MI) (Social Security Number)

_____KY_____
(Address) (City) (Zip) (Phone number)

(2) Transferred on _____from
(Date)

(3) Case Management Agency_____

_____
(Phone Number) (Provider #)

_____KY _____
(Address) (City) (Zip Code)

(4) To Case Management Agency_____

_____
(Phone Number) (Provider #)

_____KY _____
(Address) (City) (Zip Code)

(5) From Primary Provider_____

_____

(Phone) (Provider #)

_____ KY _____

(Address) (City) (Zip Code)

(6) To Primary Provider_____

_____

(Phone) (Provider #)

_____ KY _____

(Address) (City) (Zip Code)

PROCEDURAL INSTRUCTIONS FOR MAP-24C

Upon admittance/discharge/transfer and temporary discharge/re-admittance of an individual in the Supports for Community Living Program, the case manager shall forward a MAP-24C form to the local Department for Community Based Services in which the member resides and the Department for Mental Health/Mental Retardation Services. The case manager shall complete the form.

Use the following instructions to fill in the blanks on the MAP-24C:

INITIATION OF FORM

Line One (1) List the name of the County of the Department for Community Based Services the form will be sent to.

Line Two (2) List the name of person to whom the form will be sent to in the Department for Mental Health/Mental Retardation.

Line Three (3) List the name of the Case Management Agency filling out the form.

Line Four (4) List the date the form was completed.

FOR INITIAL ADMISSION TO THE SUPPORTS FOR COMMUNITY LIVING PROGRAM

Line One (1) List the name, social security number, address and phone number of the member.

Line Two (2) List the date the member entered the program.

Line Three (3) List the name of the case management agency, phone number, and provider number.

Line Four (4) List the name, phone number, provider number of the primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider.

FOR DISCHARGE FROM THE SUPPORTS FOR COMMUNITY LIVING PROGRAM

Line (1) List the name, social security number, address and phone number of the member.

Line (2) List the date the discharge.

Line (3) List the case management agency, phone number, provider number and address.

Line (4) List the name, phone number, provider number of the primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider.

FOR TRANSFER WITHIN THE SUPPORTS FOR COMMUNITY LIVING PROGRAM

Line (1) List the name, social security number, address and phone number of the member.

Line (2) List the date the transfer took place.

Line (3) List the previous case management agency, phone number, provider number and address.

Line (4) List the new case management agency, phone number, provider number and address.

Line (5) List the name, phone number, provider number of the primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider.

Line (6) List the name, phone number, provider number of the new primary provider. If the member has a residential provider, then the residential provider will be the primary provider. If the member **does not** have a residential provider, then the case management agency will be the primary provider.